VERMONT
DEPARTMENT OF HEALTH

Vermont Immunization Program

Provider Profile and Enrollment in the Vaccines for Children (VFC) Program

Physician-In-Charge: _____
(Last) (First) (MI) (Title)

State of Vermont Medical License Number: _____

Health Care Facility Name: _____

Contact Person (Office Vaccine Manager)**:** _____

Email Address: _____

Telephone Number: _____ **Fax Number:** _____

Physical Street Address: _____
(No P.O. Box)
_____

Mailing Address: □ Check here if mailing address is the same as above
_____
_____

Type of Facility:

- □ A. Public Health Department
- □ B. Public Hospital
- □ C. Private Practice (Individual or Group)
- □ D. Federally Qualified/ Rural Health Center (FQHC/RHC)
- □ E. Private Hospital
- □ F. Other Facility _____

Choose One: □ For Profit □ Not-For-Profit

NOTE: The following information is used to determine the amount of vaccine needed for your practice and **MUST** be based on actual data, not estimates.

Please document which **data source** you used for gathering your information below (e.g. benchmarking, doses administered report, Medicaid claims data, or provider encounter data, etc).

DATA SOURCE: _____

Part A. Based on the data source listed above project ONLY the **number of children who will receive vaccinations** at your health care facility by age group for a 12 month period beginning **July 1, 2006**.

< 1 Year Old	1 – 6 Years	7 – 18 Years	Total

Part B. Take the number of children in each age group entered above and indicate the number of children who are expected to be VFC eligible, by category and age group below.

*** **Underinsured**: Only a FQHC or RHC should complete the **Underinsured** row.

	< 1 Year	1 – 6 Years	7 – 18 Years	Total
Enrolled in Medicaid				
No Health Insurance				
Amer. Indian/Alaskan Native				
*** **Underinsured** (Only FQHC/RHC)				
Total				

Provider Agreement to Enroll in the Vaccines For Children (VFC) Program

In order to participate in the Vermont Department of Health (VDH) Vaccines For Children (VFC) Program, I agree to the following conditions, on behalf of myself and all the practitioners, nurses and others associated with this provider office.

1. I will screen patients (≤ 18 years of age) for VFC Program eligibility and document who qualifies under one or more of the following categories:

    a) Is an American Indian or Alaskan Native
    b) Is on Medicaid (or qualified through a State Medicaid waiver)
    c) Has no health insurance
    d) Has health insurance that does not pay for the vaccine (only applicable to FQHC or RHC)

2. I will maintain a record of the required information on VFC eligibility screening for a period of three (3) years on all VFC children. Release of such records will be bound by the privacy protection of the federal Medicaid law.

3. I will make immunization records available to the VDH Immunization Program, if requested.

4. I will permit visits to my facility by authorized representatives of the VDH Immunization Program to review compliance with VFC Program requirements including vaccine storage and record-keeping.

5. I will comply with and administer vaccines according to the appropriate immunization schedule, dosage, and contraindications that are established by the Advisory Committee on Immunization Practices (ACIP), except if the following applies:

    a) In my medical judgment, and in accordance with accepted medical practice, I deem such compliance to be medically inappropriate

    OR

    b) The particular requirement contradicts the law in my State pertaining to religious and other exemptions.

6. I will distribute Vaccine Information Statements (VIS) and document date VIS given in accordance with the National Childhood Vaccine Injury Act.

7. I will not impose a charge for the cost of the vaccine provided to my practice through federal and state funding.

8. I will not impose a charge for the administration of the vaccine that is higher than the maximum fee established by the state. I will not deny administration of a federally procured vaccine to a child because the child's parent/guardian/individual of record is unable to pay the administration fee.

9. I will comply with the following requirements for ordering, proper storage, handling and accountability of vaccine.

    a) I will report vaccine usage, waste, current inventory, and expiration dates on the Vaccine Accountability Sheets.

b) I understand that my responsibility for proper storage and handling of vaccine begins when delivery is accepted.

c) Refrigerator and freezer temperatures **MUST** be logged twice a day (once in the AM and once in the PM). Refrigerator temperatures should be (2° – 8° C) or (35° – 46° F) and freezer temperatures should be (5° F or colder) or (-15° C or colder). Any out of range temperatures **MUST** be reported to the Immunization Program immediately. Please call 1-800-464-4343 ext. 7638 or 1-802-863-7638.

d) I will keep temperature logs for three years to show proof of documented temperatures.

e) I will cooperate with the VDH to recall patients if doses were mishandled or administered incorrectly.

- If there is mishandled vaccine, the VDH Immunization Program will make every effort to work with the clinic in question to address the administration of mishandled vaccine, balancing clinic needs, cost to parents, providers and health plans, risk of illnesses or outbreaks, and overall affect on public health.
- ACIP recommendations that define and designate proper vaccine storage and handling will be followed. **IF** doses administered are of questionable potency, these doses should not be counted as valid and should be repeated.
- The VDH may offer limited resources, as available, to assist with recalls and revaccination.
- If a clinic declines to recall patients who received questionable doses, the VDH may request a list of affected patients and, in conjunction with the local health department, may conduct its own recall of these patients, in which case the clinic may be billed for the mishandled vaccine.
- If a clinic declines to provide a list of affected patients, the VDH may issue a community notice alerting patients that they have received a potentially non-viable dose of vaccine at this clinic, and encourage these patients to contact the local health department to explore revaccination.
- Recognizing the diversity of potential storage and handling issues that may arise, the VDH Immunization Program reserves the right to manage all cases of mishandled vaccine on a case-by-case basis, while adhering to the above guidelines.

f) I understand that failure to store and handle vaccines properly may result in a fine or financial liability to reimburse the VDH Immunization Program for mishandled/wasted doses.

10. I will renew enrollment annually.

11. I understand that the VDH Immunization Program may terminate this agreement at any time for failure to comply with these requirements or I may terminate this agreement at any time for personal reasons.

Signature of Physician-In-Charge	**Print Name of Physician-In-Charge**	**Date**

Additional Providers within the Practice

Provider Profile and Enrollment (continued)

Please print or type the names and medical license numbers of all health care providers in your practice (attach copies of the Additional Providers within the Practice sheet if additional space is needed).

Last Name, First, MI (Provider must have prescription writing privileges)	Medical License Number	Title (MD, DO, DN, NP, PA)

This record is to be submitted to and kept on file at the Vermont Department of Health and must be updated annually. For questions call 1-800-464-4343 ext. 7638 or 802-863-7638.

VERMONT DEPARTMENT OF HEALTH
IMMUNIZATION PROGRAM
P.O. BOX 70
108 CHERRY STREET
BURLINGTON, VT 05402

OR

FAX TO:
1-802-865-7701

Provider Agreement and Guidelines for Varicella Vaccine

ELIGIBLITY: The Vermont Department of Health Immunization Program provides varicella vaccine for the following patients ONLY: children ages 12 months through 18 years.

STORAGE REQUIREMENTS: If you wish to receive varicella vaccine you will have to complete this signed agreement showing that your practice meets the following guidelines for proper storage and handing.

a) Merck & Company, Inc. the manufacturer of VARIVAX will pack and ship varicella vaccine with dry ice directly to the provider office after receiving an order from CDC, which is submitted by the Immunization Program.

b) Varicella vaccine **MUST** be stored in a frost-free freezer, and **MUST** maintain temperatures at or below -15° C (+5° F).

c) The freezer **MUST** have a separate door from the refrigerator, (e.g. regular household refrigerator). Dorm-style or larger refrigerator/freezer combinations where the freezer is within the refrigerator is **NOT** acceptable.

d) Freezer temperatures must be recorded twice a day and any out of range temperatures **MUST** be reported to the Immunization Program immediately. Please call 1-800-464-4343 ext. 7638 or 1-802-863-7638.

e) State-Supplied varicella vaccine cannot be moved or redistributed from the provider site that received it.

ORDERING: The following is instructions for ordering varicella vaccine.

a) The minimum order of varicella vaccine is 10 doses and the maximum order is 50 doses.

b) Varicella vaccine will have at least a 12 month shelf life before expiring.

c) All varicella orders should be made by phone (1-800-464-4343 ext. 7638 or 1-802-863-7638) and can be placed weekly or as needed.

d) All varicella orders will be placed weekly on Friday afternoons to CDC by the Vermont Department of Health Immunization Program.

Practice Name: _____ **Provider Code:** _____

Contact Name: _____
(Office Vaccine Manager)

Contact Telephone Number: _____

Days and Times for Delivery:
_____
_____

I agree to the additional conditions herein for the storage, handling and use of varicella vaccine.

_____	_____	_____
Signature of Physician-In-Charge	**Print Name of Physician-In-Charge**	**Date**